Medicines Optimisation Oversight Group (MOOG)

Wednesday, 8 July 2020
9.30am – 11.00am

Attendees	
Keith Ridge (Chair)	Chief Pharmaceutical Officer, NHSE/I
Lou Patten	Chief Executive, NHS Clinical Commissioners
Michael Marsh	Regional Medical Director - South West, NHSE/I
Vin Diwakar	Regional Medical Director – London, NHSE/I
Vaughan Lewis	Regional Medical Director – South East, NHSE/I
Justine Scanlan	Head of Specialist Pharmacy Service, NHS England
Ben Rehman	Head of Medicines Optimisation, Specialist Pharmacy Service, NHS England
Jonathan Underhill	Medicines and Technologies Programme, NICE
Malcolm Qualie	Pharmacy Lead, Specialised Commissioning, NHS England
Richard Seal	Regional Chief Pharmacist – Midlands and East, NHSE/I
Michele Cossey	Regional Chief Pharmacist – North East & Yorkshire, NHSE/I
Steve Brown	Regional Chief Pharmacist – South West, NHSE/I
Richard Goodman	Regional Chief Pharmacist – London, NHSE/I
Sue Ladds	Regional Chief Pharmacist – South East, NHSE/I
Karen O'Brien	Regional Chief Pharmacist – North West, NHSE/I
Slak Dhadli	Assistant Director of Medicines Management/Clinical Policies & Decisions, NHS Derby and Derbyshire Clinical Commissioning Group
Eileen Callaghan	Head of Medicines Management, NHS Hastings and Rother CCG NHS Eastbourne, Hailsham and Seaford CCG
Richard Croker	Deputy Director for Medicines Optimisation & Lead for Pathology Optimisation, NHS Devon Clinical Commissioning Group
Sarah Crotty	Head of Pharmacy & Medicines Optimisation Herts Valleys CCG
Colette Goldrick	Director, ABPI Northern Ireland & NHS Engagement. The Association of the British Pharmaceutical Industry
Paul Fleming	Technical Director, British Generic Manufacturing Association

Gareth Arthur	Director of Strategy and Policy, Specialised Commissioning, NHSE/I
Phil Thomas (Secretariat)	Medicines Optimisation Delivery Lead, Medicines Policy Team, NHSE/I
Sue Dickinson	Specialist Pharmacy Service (Observer)
Helen Davies	Specialist Pharmacy Service (Observer)

Apologies	
Nigel Sturrock	Medical Director (Midlands), NHSE/I
Mike Prentice	Medical Director (North West), NHSE/I
David Levy	Medical Director (North East and Yorkshire), NHSE/I
Sean O'Kelly	Regional Medical Director – East, NHSE/I
Alex Williams	Deputy Director, Medicines Policy Team, NHSE/I

Item	
1	**Welcome, introduction and apologies** • The Chair welcomed colleagues to the latest meeting of the Medicines Optimisation Oversight Group (MOOG). It was noted that the format of today's meeting was different to that of a normal MOOG considering the focus and response to COIVD-19. • A round of 'virtual' introductions took place and apologies were noted.
2	**Meeting Objectives** To convene the group and: • Hear reflections and lessons learnt (national and regional response) on Covid-19; • Discuss the RMOC Work programme and emerging priorities; and, • Discuss the recovery phase.
3	**Reflections and lessons learnt (national and regional response) on Covid-19 and recovery phase.** The purpose of this agenda item was for members to hear reflections and lessons learnt from a national and regional perspective on the response to Covid-19. The Chair invited Gareth Arthur, Director of Strategy and Policy, Specialised Commissioning, NHS England & NHS Improvement to provide some general reflections from a national perspective. • COVID-19 led to a fundamental change in ways of working across the NHS and created a set of new priorities for medicines. COVID-19 placed unprecedented pressures on medicines supply and on the management of medicines within the NHS. As the NHS moves towards recovery and future planning, we have an opportunity to consider the impacts of COVID-19 and the implications for how we work • NHSE/I have considered these impacts across three broad areas: **Improving preparedness for any future pandemic** • Looking at what we need to put in place nationally or system-wide to manage any future COVID-19 waves or any future supply disruption. • Regional/National roles NHSE/I and DHSC and interface with the Emergency Preparedness Resilience and Response (EPPR) system came together well – need to think about longer term and future ways of working. • Supply chain resilience and recognising a systematic approach is required to manage the risk and supply chain planning in general, given its global nature

and numerous countries seeking the same products in high demand, so products are in scarce supply at times of peak demand for patient need.

Improving data and consistency of approach

- Reviewing what has the pandemic taught us that we can take into business as usual processes for medicines supply and the use of medicines.

- Improving data is more about consistency in approach and recognising good data supports good decision making. Trust data is generally good and helped to understand supply situation. There is an ongoing requirement for data to support both BAU and shortages. This analysis would support assessments on demand, usage and therefore commercial and procurement priorities of products and volumes. Data is also crucial for understanding the impact on clinical care.

Improving supplier and regulatory engagement

- Understanding how we work better as a system, both for future pandemics and for business as usual.

- Engagement with both suppliers and regulatory side was good. Developed good relationships with suppliers – regular contact with trade bodies and suppliers – particularly important in the first few months.

- Relationship with NICE and MHRA stronger than before COIVD-19 – MHRA on stock and what clinical alternatives could be used and NICE with developing rapid guidance. Need to maintain these relationships.

Other national things to note:

- BAU processes to manage medicines shortages were by enlarge right and the work undertaken for EU exit put us in good stead.

- Clinical formularies and clinical engagement were important and really helped in planning and preserving stock, procuring new stocks and in providing communications to the system. This helped with the approach to formularies and developing guidance.

- Managing the impact on Care Homes and ensuring medicines issues were considered.

- Did a lot of work around control drug usage and trials.

The Chair invited Steve Brown, NHS England and NHS Improvement, Regional Chief Pharmacist (South), to provide some general reflections from a regional perspective.

- The response highlighted the importance of collaborative and matrix working and what can be achieved through better cross-sector pharmacy leadership.
- The establishment of virtual systems was important and helped with engagement and operational delivery.
- With the focus on COVID-19, regions took their eye off ball with other things like medicines optimisation and finance (delivering savings).
- There were frustrations at a regional level with delays in sign-off with national documents, which made life difficult in terms of an inability to respond to escalated issues.
- In the context of future waves, collaboration, communication (both at national and regional level) is crucial - opportunity with the introduction of Teams to ensure consistency across the piece.
- Looking at business as usual and improvement going forward:
    - Care homes is a priority.
    - Further embedding of digital services in the system.
    - Being proactive rather than reactive on pharmacy/medicines related matters – focus on Electronic Prescribing and Medicines Administration (ePMA) investment paid off.
    - IPMO – crucial in getting that system working – will make implementation of IPMO work easier going forward.
    - Cross cutting work across the system was beneficial and positive.
    - Recognise a need to be more agile in ways of working going forward and recognise that a lack of agility is often a criticism for pharmacists.
    - Ongoing medium and long-term strategic workforce issues to resolve.

The chair invited reflections from members of the group and the following points were made.

- In London, the surge in demand was rapid early in the piece. For the first three weeks, we didn't know if the system was going to be overwhelmed. Getting information on ventilators/PPE was achievable in a timely manner, but it was

	hard to get a sense of key issues with medicines supply. If we do face a surge in future, a clear line of site on risks (relating to medicines) and mitigating actions is required. • There was a sense of getting information just in time at times – question if surge had been 50% greater would it have been true. It got close to the wire with some of the critical care drugs – future surges going to be regional rather than across the whole system. If we are to maintain surgical activity during a second wave – is there going to be sufficient medicines to meet demand. • From a primary care perspective. There was a lot of mixed messages coming from community pharmacists and local wholesalers. Nimbleness and delays in national advice was an issue – stockpiling drugs at Care Homes – case of making it up in the absence of a national steer. Seemingly simple things like getting NHSE to set up new prescribing codes takes weeks e.g. for a hospice to prescribe EoL care – still waiting after a month. • About national guidelines/guidance. Reflecting on the approach taken and looking at it the other way around – we need to look at how we get them out quicker – getting sign-off in a more-timely manner. RMOCs can play a role to an extent in providing a view on what topics require guidance. • A point was made relating to guidance and how in the absence of anything being published nationally in a timely manner, it was being written locally on things like DOACs, B12, Palliative Care and Shared Care and replicated across the country. • The issue of regional line of sight was raised a few times by national response group and Steve Powes. Some of it was being managed nationally via Regional Procurement Pharmacy Specialists – acknowledge the relationship between EPPR and national team wasn't always great and need to review. Data was also a contributing factor which improved over time. • Having a complete picture on national medicines supply and clarity on who in the regions were being sighted was important. Echo the comment on the impact of delays associated with communications – pragmatic approach required to advise regions. Can't silo medicines to just pharmacy, need to widen out as it impacts across the board. • Supply issues have been kept in the pharmacy world for some time and acknowledge the wider implications. The UK wide approach for COVID-19 was new. NHSE/I worked with DHSC a lot but working across DA's and getting sign-off is always challenging - raising things at top of the office earlier maybe a way of improving things. Royal College engagement in a timely manner is important and they did publish guidance in some instances.

- The (CAS) alert system enabled supply disruptions communications to get out to the system. As a mechanism for issuing communications, it helped raise the profile of system to other parts of the organisation.

- The incident center/EPPR link is important. Ensuring professional expertise is given to senior members of an ICS in a timely fashion is critical. RMOC needs to learn and get better at issuing guidance in a more-timely manner. Local cells/tripartite groups linked to EPPR were established and led to clinical input being obtained in a much quicker way during the response.

- Whilst we have good working relationships with Royal Colleges/Faculty of Emergency and Critical Care and is effective at a national level. Can that be replicated at a regional level? Identifying a regional (College/Faculty) lead to work with the regions may have been beneficial.

- Something to consider about developing clinical guidance and the role of RMOCs. RMOCs could be used to raise issues and advise on drafts of emerging guidance. ICUs/chemo dose banding for example. RMOCs could help here with standardisation in conjunction with Royal Colleges.

- The issue of resourcing was raised and the importance of acknowledging resource implications with RMOCs taking on additional responsibilities, and especially in the context of moving to 6/7 RMOCs going forward.

- A further point was made in relation to the criticism associated with RMOCs is the speed of issuing advice/guidance, and acknowledging it is something that needs to improve going forward.

The chair brought the agenda item to a close.

Recovery Phase

At this point in the meeting, the chair decided to focus on agenda item three. Building on the previous discussion, the chair invited comments from members in relation to the role RMOCs can play in supporting work on the recovery phase.

The following points were made:

- NHSE/I recognise the importance of providing the system with reassurance on the resilience of the supply chain moving forward – learning from COVID-19 (first wave) and how that translates for responding to any future outbreaks or further spikes.

- BGMA raised they are finalising a piece of work on resilience of supply, taking the lessons learnt from COVID and how the supply chain for biosimilar & generic medicines can be strengthened by ensuring that there are multiple suppliers at all levels of the supply chain; that the supply chain itself holds sufficient volumes to give time to increase production in times of emergency;

	and that there is sufficient diversity and flexibility in manufacturing and regulation to allow manufacturing to be ramped up or changed to other products quickly in the time bought by those increased volumes in the supply chain.
	
	• In recognising there is an issue at a national level in terms of priorities and issuance of guidance by NHSE/I. RMOCs could help with the prioritisation process through providing input from a medicine's perspective, as well as providing comments/sense-checking the content of draft/emerging guidance.
	
	• ePMA – RMOCs should be trying to support its ongoing role out and implementation.
	
	• Valproate - report has been received and considered with far reaching implications. RMOCs can play a role with supporting implementation and elements of which would benefit from standardisation i.e. done once.
	
	• More work to be done on regional national formularies/guidance with a focus on standardisation of medicines presentations, concentration and strengths – surgery/cancer for example.
	
	• Aseptic review and radio pharmacy – consideration required on how RMOCs can support implementation.
	
	• There are two medicines optimisation priorities to consider:
	
	  • PHE work on dependencies/addiction to prescribed medicines - a report is due to go to SofS in September. Analysts have been asked to look at the data to see if there is anything specifically from a BAME perspective to be aware of.
	
	  • environmental sustainability – reducing waste, carbon footprints etc.
	
	• A point was made in relation to COVID-19 and the medicine optimisation priorities about general issues related to health inequalities. It is well documented BAME groups at greater risk and the medicines system should reflect on this.
	
	• There was consensus amongst the group that there is topics that are on local APC agendas that would benefit from RMOC involvement and a standardised approach. Individual committees should engage with their local APCs to understand priorities which would be suitable for RMOCs to pick up.
	
	• In relation to the previous point, it was highlighted there is an opportunity for RMOCs to work closely with ICSs to identify medicines optimisation priorities that would a) benefit from a national standardised approach and b) reduce unwarranted variation.

	The chair brought the agenda item to a close.
4	**RMOC work programme – emerging priorities/future constitution** The Chair invited Phil Thomas, Medicines Optimisation Delivery Lead, NHS England and NHS Improvement, to set the context. • The previous discussion on how RMOC can support the recovery phase highlighted several potential areas for inclusion on RMOC work programmes, as well as potential further opportunities which may result from engagement with local stakeholders. • A copy of the RMOC work programme was circulated in advance of the meeting. However, it was acknowledged that what RMOC were working on before COVID-19 might not necessarily be what is required now, and clinician availability for meetings for the foreseeable is likely to be an issue. That said, there needs to be a retained focus on supporting implementation of national priorities such as MVP MO priorities and Shared Care. • RMOCs reopening for business is a general point for discussion as it had not been discussed earlier in the meeting. The suggestion was they should look to reconvene from September. A suggestion that was broadly supported by the group. • It was acknowledged that further work is required to operationalise the operating model as was the case pre COVID-19. Linked to the future of RMOC and their work programme is the ongoing issue of resources. As heard at previous MOOG discussion, unless the RMOCs have appropriate resources in place within the regions, it will severely impact their ability to deliver. • The group were updated that the business case that was drafted at the start of the year is being revisited. In part, the suggestion of RMOC recommencing in September is to provide NHSE/I with 4 to 6 weeks to submit the business case for consideration. The chair invited comments from members and the following points were made: • Shared care is an immediate priority, particularly as the guidance developed by the North committee can support the recovery phase. • It was suggested there is an opportunity for RMOCs to support local decision makers with MO priorities identified as part of QIPP plans. Which links to previous discussions around RMOCs engaging with local decision makers. • It was highlighted work is underway in some regions to refresh RMOC membership to reflect local/regional structures e.g. ICSs/STPs.

	• In was also highlighted some regions are turning their attention to transitioning from four RMOCs but there remained some concerns given the ongoing uncertainty about resources. The chair brought the agenda item to a close.
• 7	**Conclusion** • The national RMOC day was raised and given the current circumstances the group was informed there would not be a face-to-face event this year. There was general agreement that consideration should be given to the merits of running a virtual event. **Action: PT to consider options and explore further what the focus of an event would look like.** The chair brought the meeting to a close, and thanked members for their contribution. The next meeting of the group is scheduled for 23 September 2020.